		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035188

Facility Name: Lexington Health Care Center-Bloomingdale

Address: 165 S. Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630) 980-8700 **Fax #** (630) 980-6170

IDPA ID Number: 363635151001

Date of Initial License for Current Owners: 05/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT			X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.				Individual		State
	Trust				Partnership		County
IRS Exemption Code					Corporation		Other
				X	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,952	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,952	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,523	4,373	4,185	33,081	8
9	SNF/PED					9
10	ICF	13,881	1,910	681	16,472	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,404	6,283	4,866	49,553	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.72%

D. How many bed-hold days during this year were paid by Public Aid?
2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 5/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 40 and days of care provided 3,778

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	246,942	27,479	9,941	284,362		284,362		284,362			1
2	Food Purchase		212,156		212,156		212,156	(9,555)	202,601			2
3	Housekeeping	270,129	37,633		307,762		307,762		307,762			3
4	Laundry	33,514	29,488		63,002		63,002	(3,977)	59,025			4
5	Heat and Other Utilities			184,071	184,071		184,071	1,747	185,818			5
6	Maintenance	57,734		127,758	185,492		185,492	208	185,700			6
7	Other (specify):*											7
8	**TOTAL General Services**	608,319	306,756	321,770	1,236,845		1,236,845	(11,577)	1,225,268			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,860,508	184,057	378,448	2,423,013		2,423,013		2,423,013			10
10a	Therapy			463,106	463,106		463,106		463,106			10a
11	Activities	134,733	13,393	2,864	150,990		150,990	13	151,003			11
12	Social Services	51,012		3,609	54,621		54,621		54,621			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,046,253	197,450	860,027	3,103,730		3,103,730	13	3,103,743			16
	C. General Administration											
17	Administrative	88,094		293,036	381,130		381,130	(293,036)	88,094			17
18	Directors Fees											18
19	Professional Services			108,754	108,754		108,754	(278)	108,476			19
20	Dues, Fees, Subscriptions & Promotions			63,031	63,031		63,031	3,312	66,343			20
21	Clerical & General Office Expenses	255,790	35,143	20,414	311,347		311,347	17,494	328,841			21
22	Employee Benefits & Payroll Taxes			398,079	398,079		398,079	44,016	442,095			22
23	Inservice Training & Education			500	500		500	217	717			23
24	Travel and Seminar			2,377	2,377		2,377	346	2,723			24
25	Other Admin. Staff Transportation							6,797	6,797			25
26	Insurance-Prop.Liab.Malpractice			32,118	32,118		32,118	1,388	33,506			26
27	Other (specify):*											27
28	**TOTAL General Administration**	343,884	35,143	918,309	1,297,336		1,297,336	(219,744)	1,077,592			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,998,456	539,349	2,100,106	5,637,911		5,637,911	(231,308)	5,406,603			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** **SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale #0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			50,327	50,327		50,327	173,303	223,630			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,100	9,100		9,100	318,828	327,928			32
33	Real Estate Taxes							116,022	116,022			33
34	Rent-Facility & Grounds			1,074,820	1,074,820		1,074,820	(1,074,820)				34
35	Rent-Equipment & Vehicles			467	467		467	296	763			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,134,714	1,134,714		1,134,714	(466,371)	668,343			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,355	9,576	81,931		81,931		81,931			39
40	Barber and Beauty Shops			11,814	11,814		11,814		11,814			40
41	Coffee and Gift Shops			645	645		645		645			41
42	Provider Participation Fee			94,428	94,428		94,428		94,428			42
43	Other (specify):* **Nonallowable costs**			72,483	72,483		72,483	(72,483)				43
44	**TOTAL Special Cost Centers**		72,355	188,946	261,301		261,301	(72,483)	188,818			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,998,456	611,704	3,423,766	7,033,926		7,033,926	(770,162)	6,263,764			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(32)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,977)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,701)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(779)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,070)	43		18
19	Entertainment				19
20	Contributions	(75)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,289)	43		24
25	Fund Raising, Advertising and Promotional	(5,270)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,284)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(7,660)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,137)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(673,025)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (673,025)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (770,162)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington Health Care Center-Bloomingdale

ID# 0035188

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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31				31
32				32
33				33
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73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	22.33%			Sambell of Bloomingdale		
John Samatas	22.33%	See attached Schedule B		Limited Partnership	Bloomingdale	Real estate ptsp.
Cynthia Thiem	22.34%			Royal Mgmt. Corp	Lombard	Mgmt. Co.
Jeffrey Bell, James Bell Declaration of				Lexington Financial		
Trust, Larry Bell and David Bell each	33.00%			Services, L.L.C.	Lombard	Finance Co.
owning 8.25%						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,074,820	Sambell of Bloomingdale Limited Partnership	**	$	$ (1,074,820)	1
2	V	30	Depreciation		Sambell of Bloomingdale Limited Partnership	**	163,664	163,664	2
3	V	32	Interest expense		Sambell of Bloomingdale Limited Partnership	**	322,795	322,795	3
4	V	32	Amortization of mortgage costs		Sambell of Bloomingdale Limited Partnership	**	4,146	4,146	4
5	V	33	Property taxes		Sambell of Bloomingdale Limited Partnership	**	114,820	114,820	5
6	V	43	State replacement tax		Sambell of Bloomingdale Limited Partnership	**	3,284	3,284	6
7	V	21	Bank charges		Sambell of Bloomingdale Limited Partnership	**	110	110	7
8	V	21	Administrative expenses		Sambell of Bloomingdale Limited Partnership	**	4,041	4,041	8
9	V	19	Professional fees		Sambell of Bloomingdale Limited Partnership	**	119	119	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,074,820			$ 612,979	$ * (461,841)	14

** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Sambell of Bloomingdale Limited Partnership

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	**	$	$ 18,559	15
16	V	22	FUTA		Royal Management Corp.	**		385	16
17	V	22	SUTA		Royal Management Corp.	**		1,035	17
18	V	22	Insurance - W/C		Royal Management Corp.	**		218	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**		9,386	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**		4,910	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**		3,091	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**		1,716	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**		4,832	23
24	V	33	Property taxes		Royal Management Corp.	**		1,202	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**		990	25
26	V	26	Insurance - general		Royal Management Corp.	**		1,388	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**		447	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**		1,459	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**		288	29
30	V	11	Activities Consultant		Royal Management Corp.	**		13	30
31	V	35	Equipment rental		Royal Management Corp.	**		296	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**		2,860	32
33	V	25	Auto expense		Royal Management Corp.	**		6,797	33
34	V	21	Bank charges		Royal Management Corp.	**		215	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**		4,207	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**		452	36
37	V	21	Office supplies & printing		Royal Management Corp.	**		5,458	37
38	V	21	Postage		Royal Management Corp.	**		2,038	38
39	Total			$			$ 0	$ * 72,242	39

** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	**	$	$ 984	15
16	V	6	Security service		Royal Management Corp.	**		10	16
17	V	21	Telephone		Royal Management Corp.	**		5,827	17
18	V	21	Communications		Royal Management Corp.	**		419	18
19	V	24	Travel & seminar		Royal Management Corp.	**		565	19
20	V	32	Interest		Royal Management Corp.	**		1,588	20
21	V	23	Training & education		Royal Management Corp.	**		217	21
22	V	17	Management fees	293,036	Royal Management Corp.	**		(293,036)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 293,036			$ 0	$ * (283,426)	39

** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdal(# 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	4	8.00%	Salary	$ 21,544	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	4.00%	Salary	9,575	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	5.00%	Salary	11,970	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	3,830	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2	5.00%	Salary	6,367	L17, C1	5
6											6
7											7
8							All individuals worked in excess of 40 hour per week				8
9											9
10											10
11											11
12											12
13								TOTAL	$ 53,286		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	62,952	$ 18,559	1
2	22	FUTA	Bed Days	788,945	11	4,830		62,952	385	2
3	22	SUTA	Bed Days	788,945	11	12,967		62,952	1,035	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		62,952	218	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		62,952	9,386	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		62,952	4,910	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		62,952	3,091	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		62,952	1,716	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		62,952	4,832	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		62,952	1,202	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		62,952	990	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		62,952	1,388	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		62,952	447	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		62,952	1,459	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		62,952	288	15
16	11	Activity consultant	Bed Days	788,945	11	167		62,952	13	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		62,952	296	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		62,952	2,860	18
19	25	Auto expense	Bed Days	788,945	11	85,184		62,952	6,797	19
20	21	Bank charges	Bed Days	788,945	11	2,695		62,952	215	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		62,952	4,207	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		62,952	452	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		62,952	5,458	23
24	21	Postage	Bed Days	788,945	11	25,535		62,952	2,038	24
25	TOTALS					$ 905,395	$		$ 72,242	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	62,952	$ 984	1
2	6	Security Service	Bed Days	788,945	11	127		62,952	10	2
3	21	Telephone	Bed Days	788,945	11	73,022		62,952	5,827	3
4	21	Communications	Bed Days	788,945	11	5,248		62,952	419	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		62,952	565	5
6	32	Interest	Bed Days	788,945	11	19,899		62,952	1,588	6
7	23	Training & Education	Bed Days	788,945	11	2,716		62,952	217	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 9,610	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	x		Mortgage	Varies	2/1/96	5,575,000	4,971,250	02/06/2026	Variable	322,795	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	x		Working Capital	None	Various	744,845	135,945	Demand	0.0550	9,100	6
7												7
8												8
9	TOTAL Facility Related						$ 6,319,845	$ 5,107,195			$ 331,895	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,146	10
11								Interest Income offset			(9,701)	11
12								Management company allocation			1,588	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,967)	14
15	TOTALS (line 9+line14)						$ 6,319,845	$ 5,107,195			$ 327,928	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 120,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 114,820	2
	Allocated from management company	1,202	
3. Under or (over) accrual (line 2 minus line 1).		$ (3,978)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 120,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 116,022	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	106,458	8
1996	107,346	9
1997	112,356	10
1998	114,528	11
1999	114,820	12

1999 tax:	114,820
Estimated increase:	1.05
Estimated 2000 taxes:	120,561
Use:	120,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	43,000	1987	$ 402,548	1
2					2
3	TOTALS	43,000		$ 402,548	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 993,907	4
5	9		1992	1992	178,974		35	5,114	5,114	46,023	5
6	75		1994	1994	2,022,894		35	57,797	57,797	375,680	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674	184	10	184		3,673	10
11	Building Improvements			1991	2,586	259	10	259		2,458	11
12	Building Improvements			1992	3,154	315	10	315		2,681	12
13	Building Improvements			1993	1,582	158	10	158		1,186	13
14	Building Improvements			1994	15,734	1,573	10	1,573		10,227	14
15	Land Improvements			1994	1,381	138	10	138		898	15
16	Land Improvements			1995	1,074		15	72	72	394	16
17	Building Improvements			1995	1,288		35	37	37	219	17
18	Building Improvements			1995	9,433	270	35	270		1,485	18
19	Building Improvements			1995	43,839	1,252	35	1,252		6,886	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation			1996	8,706	298	10-35	298		1,342	21
22	Land Improvements - drain tile system			1996	7,858		15	524	524	2,358	22
23	Resident room heaters			1997	3,563	102	35	102		407	23
24	Automatic doors			1997	12,950	370	35	370		1,141	24
25	Basement renovation			1997	58,806	5,936	10	5,936		18,797	25
26	Land Improvement - outdoor flagpoles			1997	1,574	105	15	105		367	26
27	1st Floor Remodel (Nurses Station/Lounge)			1998	76,487	7,649	10	7,649		19,122	27
28	Wiring for MDS			1998	4,506	451	10	451		1,127	28
29	Flag Pole			1998	787	79	10	79		197	29
30	Resuface/Stripe Parking Lot			1998	9,777	978	10	978		2,445	30
31	Kitchen tile/paint			1999	718	72	10	72		108	31
32	1st Floor Remodel - Republic			1999	3,296	330	10	330		660	32
33	Roof repairs			2000	5,748	192	15	192		192	33
34	Sump pump			2000	2,534	127	10	127		127	34
35	Sump pump basin repair			2000	6,306	315	10	315		315	35
36	TOTAL (lines 4 thru 35)				$ 5,479,172	$ 21,153		$ 169,889	$ 148,736	$ 1,503,502	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic door closers			2000	1,300	43	15	43		43	9
10	Carpeting			2000	5,866	293	10	293		293	10
11											11
12											12
13	Allocated from management company			1995	8,122		35	251	251	1,276	13
14	Allocated from management company			1996	6,610		35	204	204	850	14
15	Allocated from management company			1989	228		31	7	7	93	15
16	Allocated from management company - HVAC			1998	171		35	5	5	15	16
17	Allocated from management company - Offices			1999	432		35	13	13	19	17
18	Allocated from management company - Offices			2000	205		35	6	6	4	18
19	Allocated from management company			1987	37,969		31	1,176	1,176	15,423	19
20	Allocated from management company			1993	20		39	1	1	4	20
21	Allocated from management company			1995	855		39	26	26	120	21
22	Allocated from management company			1996	171		39	5	5	19	22
23	Allocated from management company - Sidewalk			1998	358		39	11	11	22	23
24	Allocated from management company - Roof			1998	13		15	1	1	3	24
25	Allocated from management company - Awnings			1999	221		39	7	7	32	25
26	Allocated from management company - Parking lot			1999	101		15	3	3	4	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 62,642	$ 336		$ 2,052	$ 1,716	$ 18,220	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 341,817	$ 23,812	$ 38,740	$ 14,928	5-10 years	$ 183,978	37
38	Current Year Purchases	95,010	5,026	5,026		5-10 years	5,026	38
39	Fully Depreciated Assets	240,296					240,296	39
40	Allocated from Mgmt. Co.	47,609		4,832	4,832		33,692	40
41	TOTALS	$ 724,732	$ 28,838	$ 48,598	$ 19,760		$ 462,992	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45	Allocated from Mgmt. Co.			20,627		3,091	3,091		12,677	45
46	TOTALS			$ 20,627	$	$ 3,091	$ 3,091		$ 12,677	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,689,721	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 50,327	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 223,630	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 173,303	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,997,391	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 763 Description: Copier: $467; Allocated from management company: $296
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A,C3	hrs	$	14,905	$	197,317	$	14,905	$ 197,317	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		1,419		12,877		1,419	12,877	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10A,C3	hrs		21,646		252,912		21,646	252,912	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39,C2	# of prescrpts					72,355		72,355	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Oxygen	L39,C3					8,082			8,082	13
	Laboratory	L39,C3					1,494			1,494	
14	TOTAL			$	37,970	$	472,682	$ 72,355	37,970	$ 545,037	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 157,436	$ 162,748	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 246,971)	1,102,972	1,102,972	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,969	24,969	6
7	Other Prepaid Expenses	413	413	7
8	Accounts Receivable (owners or related parties)	49,056	43,962	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,334,846	$ 1,335,064	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	102,212	102,212	12
13	Land		402,548	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	284,307	359,083	15
16	Equipment, at Historical Cost	313,552	745,359	16
17	Accumulated Depreciation (book methods)	(192,309)	(1,997,391)	17
18	Deferred Charges		9,978	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Loan Costs		83,600	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 507,762	$ 4,888,120	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,842,608	$ 6,223,184	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,644	$ 212,644	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	135,945	135,945	29
30	Accrued Salaries Payable	146,929	146,929	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,384	3,384	31
32	Accrued Real Estate Taxes(Sch.IX-B)		120,000	32
33	Accrued Interest Payable		18,971	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	228,694	116,148	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 727,596	$ 754,021	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,971,250	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,971,250	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 727,596	$ 5,725,271	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,115,012	$ 497,913	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,842,608	$ 6,223,184	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 978,514	1
2	Restatements (describe):		2
3	**Prior year post closing entries**	(64,300)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 914,214	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	200,798	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 200,798	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,115,012	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,674,104	1
2	Discounts and Allowances for all Levels	(516,601)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,157,503	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	767,139	6
7	Oxygen	1,260	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 768,399	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,536	12
13	Barber and Beauty Care	14,928	13
14	Non-Patient Meals	32	14
15	Telephone, Television and Radio	111	15
16	Rental of Facility Space		16
17	Sale of Drugs	95,110	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,679	19
20	Radiology and X-Ray		20
21	Other Medical Services	168,479	21
22	Laundry	3,977	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 292,852	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,701	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,701	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	6,269	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,269	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,234,724	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,236,845	31
32	Health Care	3,103,730	32
33	General Administration	1,297,336	33
	B. Capital Expense		
34	Ownership	1,134,714	34
	C. Ancillary Expense		
35	Special Cost Centers	166,873	35
36	Provider Participation Fee	94,428	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,033,926	40
41	**Income before Income Taxes (line 30 minus line 40)****	200,798	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 200,798	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. This entity files a cash basis tax return**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	952	952	$ 28,377	$ 29.81	1
2	Assistant Director of Nursing	2,293	2,332	52,345	22.45	2
3	Registered Nurses	28,720	30,690	696,020	22.68	3
4	Licensed Practical Nurses	7,961	8,362	165,210	19.76	4
5	Nurse Aides & Orderlies	75,370	77,678	830,233	10.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,794	7,331	88,323	12.05	8
9	Activity Director	1,890	1,913	25,477	13.32	9
10	Activity Assistants	12,101	12,551	109,256	8.70	10
11	Social Service Workers	3,981	4,110	51,012	12.41	11
12	Dietician	158	168	3,423	20.38	12
13	Food Service Supervisor	2,487	2,495	32,252	12.93	13
14	Head Cook	2,134	2,134	24,981	11.71	14
15	Cook Helpers/Assistants	12,171	12,561	77,634	6.18	15
16	Dishwashers	12,684	13,332	108,652	8.15	16
17	Maintenance Workers	3,975	4,219	57,734	13.68	17
18	Housekeepers	38,735	40,471	270,129	6.67	18
19	Laundry	5,377	5,505	33,514	6.09	19
20	Administrator	952	1,111	34,808	31.33	20
21	Assistant Administrator					21
22	Other Administrative	517	530	53,286	100.54	22
23	Office Manager					23
24	Clerical	14,984	16,013	255,790	15.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	234,236	244,458	$ 2,998,456 *	$ 12.27	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,941	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	28	1,375	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,864	L11, C3	44
45	Social Service Consultant	Monthly	3,609	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	28	$ 30,989		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	11,714	$ 234,271	L10, C3	50
51	Licensed Practical Nurses	2,272	38,629	L10, C3	51
52	Nurse Aides	6,068	97,085	L10, C3	52
53	TOTAL (lines 50 - 52)	20,054	$ 369,985		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sally Jones	Administrator	0.00%	$ 8,131
Karen Fogel	Administrator	0.00%	13,569
Debra Patty	Administrator	0.00%	5,833
Robart Van Rhee	Administrator	0.00%	7,275
See attached Schedule E			53,286
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,094

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 293,036
TOTAL (agree to Schedule V, line 17, col. 3)	$ 293,036
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Insurance & Annuity Co.	401(k) Administration	$ 285
Altschuler, Melvoin & Glasser	Accounting	17,322
American Express Tax & Bus. Svcs.	Accounting	6,760
Cemco Consultants	Recruitment	18,000
Christine Toolan, R.R.A	Consulting	60
Holleb & Coff	Legal	26,192
James Samatas	Legal	100
Personnel Planners	U/C Consulting	836
Royal Management	Website Development	338
Sachnoff & Weaver	Legal	515
Systematic Management	Billing Consulting	15,727
See attached Schedule E		22,619
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 108,754

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,967
Unemployment Compensation Insurance	28,115
FICA Taxes	223,754
Employee Health Insurance	55,095
Employee Meals	9,523
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	9,390
CNA Transportation	79,056
Other employee benefits	7,195
TOTAL (agree to Schedule V, line 22, col.8)	$ 442,095

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	61,279
Health Care Worker Background Check	
(Indicate # of checks performed 46)	552
Miscellaneous Permits & Fees	975
Miscellaneous Dues & Subscriptions	225
Allocated from management company	3,312
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,343

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,158
Allocated from management company	565
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,723

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance	Various, 1996	4,144	3	691	1,381	1,381	$ 691	$	$	$	$	$
2	Deferred Maintenance	Various, 1998	7,698	3		1,283	2,566	2,566	1,283				
3	Painting & Decorating	2/1998	1,660	3		277	553	553	277				
4	Deferred Maintenance	2/1999	4,043	3			674	1,348	1,348	673			
5	Painting & Decorating	Various, 2000	7,676	3				1,279	2,559	2,559	1,279		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 25,221		$ 691	$ 2,941	$ 5,174	$ 6,437	$ 5,467	$ 3,232	$ 1,279	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,557** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **N/A**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **94,428**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,523** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **32**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.